

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$11,942.00 for dates of service commencing on 01/09/01 and extending through 03/07/01.
- b. The request was received on 02/19/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA(s)
 - c. EOB/TWCC 62 forms/Medical Audit summary
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. Medical Audit summary/EOB/TWCC 62 form
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/25/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/28/02. The response from the insurance carrier was received in the Division on 07/15/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.
3. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Noted on the Table of Disputed Services

“Requestor’s usual and customary fee for these services is \$180.00 per unit (hour)....As the carrier paid the claims, (Requestor’s) bills were incorrectly reduced. The carrier provided as its basis for reduction the following: CPT Code –97799-CP – Code ‘M’ – ‘Reduced to fair and reasonable’....(Requestor) objects to (Carrier’s) description, specifically, (Carrier’s) argument that his usual and customary charge for CPT code 97799-CP of \$180.00/unit was reduced to ‘fair and ‘reasonable’. Since there is not MAR established for this code, the carrier may not arbitrarily reduce (Requestor’s) usual and customary charge. (Carrier) failed to provide any documentation as to how they determined that there is a medical fee guideline or maximum allowable reimbursement (MAR) applicable to CPT code 97799-CP.”
2. Respondent: Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 03/02/01, 03/05/01, 03/06/01 and 03/07/01. The request for medical dispute resolution was received on 02/19/02. Dates of service commencing on 01/09/01 and extending through 02/16/01 are out of jurisdiction for review per TWCC Rule 133.305 (d) (1) and will not be addressed.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor’s Table of Disputed Services, the Requestor billed the Carrier \$2,880.00 for services rendered on the remaining dates in dispute.
4. Per the Requestor’s Table of Disputed Services, the Carrier paid the Requestor \$888.00 for services rendered on the remaining dates in dispute.
5. The amount in dispute is \$1,992.00 for services rendered on the remaining dates in dispute.
6. The Carrier’s EOBs deny additional reimbursement as “Z1 Pre-Authorization required under chapter 134, Provider did request and the request was denied; F Reduction According to Fee Guideline; M Reduced to Fair & Reasonable”.
7. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
03/02/01 03/05/01 03/06/01 03/07/01	97799-CP 97799-CP 97799-CP 97799-CP	\$720.00 \$720.00 \$720.00 \$720.00	\$0.00 \$296.00 \$296.00 \$296.00	A, F A, F A, F A, M	No MAR	TWCC Act & Rules Sec 413.011 (d); 134.600 (h) (15); 133.304 (i); 133.307 (3) (g) (D); and 133.307 (j) (1) (F)	<p>The Carrier has denied all dates of service as "Z1 Pre-Authorization required under chapter 134, Provider did request and the request was denied". Pursuant to TWCC Rule 134.600 (h) (15), effective 04/01/97, "...pain clinics..." must be pre-authorized. The Requestor has not submitted proof of pre-authorization.</p> <p>The Carrier also denied dates of service 03/02/01, 03/05/01 and 03/06/01 as "F Reduction According to Fee Guideline". However CPT code 97799-CP is a DOP (no MAR) per the MFG. The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes... HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate "(bolded for emphasis). The Carrier also denied date of service 03/07/01 as "M", reduced to fair and reasonable. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:</p> <ol style="list-style-type: none"> develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement; explain and document the method it used to calculate the rate of pay, and apply this method consistently; reference its method in the claim file; and explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement." <p>The response from the carrier shall include, per Rule 133.307 (j) (1) (F), "... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;"</p> <p>The Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of fair and reasonable. As the Requestor, the health care provider has the burden to provide documentation that "...discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement..." pursuant to TWCC Rule 133.307 (3) (g) (D). The Requestor has not submitted any documentation to support the fee billed is fair and reasonable. Therefore, no additional reimbursement is recommended.</p>
Totals		\$2880.00	\$888.00				The Requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 12th day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt